2021-2022 ROWER MEDICAL AUTHORIZATION & INFORMATION

Rower's Name: ____

School: __________________________Birthdate:_____/_____/_____ Grade: _______

Height________________

Primary Household Address:
Address (please print): ____

City_______________________ Zip___________ Home Ph (_____) __________________

Parent(s) or Guardian(s) Name(s):
Parent 1 name (please print): ____
Cell (_____)______________________ Work(_____)_____________________
Parent 1 email address (please print): ____

Parent 2 name (please print): ____
Cell (_____)______________________ Work(_____)_____________________
Parent 2 email address (please print): ____

Rower email address (please print): ____
Rower's cell: (_____)___________________________

If your rower has two households, please provide further information below:
Name(s) (please print): ____
Address (please print): ____
City________________________Zip___________
Home Ph (_____) __________________
Cell (_____) __________________________
email address:_______________________________

Emergency Medical Information
Rower's Physician: ______________________________
Phone: ______________________

Emergency Medical Information (Cont.)

In-state hospital preference:____

Medical History:
Rowers who need inhalers, epi pens, glucose and/or insulin must bring these to practice! Please let us know if you have any learning differences, ADD or receive learning accommodations at school. Our coaches will work with your learning style to make sure that your rowing experience is a successful one. Please provide as much information as possible on how you learn best.

Allergies: ____

Prescription medications: (including insulin, epi pens, ADD and ADHD medications)

____

Known Medical Conditions/Learning Issues/Comments:

____

____

Insurance Information: (Please attach a copy of your insurance card-front and back)

Insurance Carrier: ____________________________

Policy / Group #: _____________________

Policy holder's name: ______________________________

Employer: __________________________________

Insurance telephone: ________________________

Insurance address:

____

____

Emergency Contact Information:

1) Name: ____________________________ Relationship: __________________

Home Tel: (_____) ________________ Cell # (_____) ______________________

2) Name: ____________________________ Relationship: __________________

Home Tel: (_____) ________________ Cell # (_____) ______________________

Authorization to Treat a Minor / Medical & Liability Release

I am fully aware of and appreciate the risks and other damages and losses associated with participation in this rowing program. I agree that (a) the Mile High Rowing Club: (b) associated coaches, volunteers, board members and parents, as a group or as individuals, assume no liability or financial obligation for any loss, accident or illness incurred by the above named participant in the course of his/her association with the program. The above named participant/rower is in good physical condition with no limitations. There are no known diseases, mental or physical conditions or medications taken that could result in the participant being harmed by this program. While I understand that hospital / physician / coaches will try to contact me, as the parent/guardian of the above named participant/rower, I authorize in my absence the emergency evaluation and treatment deemed necessary by the attending physician in the case of an accident or illness.

I (we) the undersigned parent(s) or legal guardian(s) of the rower,/participant listed below, a minor, do hereby authorize and consent for medical treatment as deemed necessary by an emergency room physician. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that the effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. I understand that I am responsible for the costs of all medical treatment.

Name of Participant/Rower: ____

Parent/Guardian Acknowledgement:

Name (Please Print): __________________________

Signature: ______________________________

Date: _______________